STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	10/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaints IN00117692 and IN00118202. This resulted in a partially extended survey- Past Non Compliance Immediate Jeopardy. Complaint IN00117692-Substantiated. Federal/state deficiencies related to the allegations are cited at F329, F333, F505, and F999. Complaint IN00118202-Substantiated. Federal/state deficiencies related to the allegation are cited at F329, F333, and F505. Survey date: October 22, 2012 Extended survey date: October 23, 2012 Facility number: 010739 Provider number: 155764 AIM number: 200856890 Survey team: Janet Adams, RN Census bed type: SNF: 49 SNF/NF: 5	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Residential: 64 Total: 118 Census payor type: Medicare: 42 Medicaid: 5 Other: 71 Total: 118 Sample: 6 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on October 26, 2012 by Bev Faulkner, RN			

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F0329 SS=J	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure monitoring related to analyzing and acting upon laboratory tests for therapeutic levels was in place in order to minimize potential adverse consequences and failed to ensure the administration of the correct dose of an anticoagulant medication, which resulted in gastrointestinal bleeding requiring hospitalization for 1 of 3 residents reviewed for the use of anti-coagulant medications in the sample of 6. (Resident #E)	F0329	Past non-compliance POC not required.	11/22/2012

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Due to the lack of monitoring this deficient practice had the potential to affect 13 of 13 residents receiving anticoagulant therapy of the 54 residents residing on the health care units of the facility of the the total 118 residents residing in the facility.

The Immediate Jeopardy began on 10/8/12 when Resident #E received the incorrect dose of Coumadin (an anticoagulant medication) and the error was not identified until 10/11/12 when the resident developed an onset of gastrointestinal bleeding requiring the hospitalization for the transfusion of fresh frozen plasma (blood product to maintain coagulation). The facility Interim Executive Director, Clinical Support Nurse, and the Risk Management Nurse were informed of the Immediate Jeopardy on 10/23/12 at 11:00 a.m. The Immediate Jeopardy was removed and the deficient practice corrected on 10/12/12, prior to the start of the survey and was therefore Past Noncompliance.

Findings include:

The record for Resident #E was reviewed on 10/22/12 at 10:30 a.m. The resident's diagnoses included, but were not limited to, colon cancer, renal failure, high blood

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	pressure, and arthritis. The resident was admitted to the facility on 10/3/12. The resident was sent to the hospital on 10/11/12 and was readmitted to the facility on 10/15/12. Review of the 10/12 Physician orders indicated there was an order written on 10/3/12 for the resident to receive Coumadin (a medication to prevent blood clotting risk) 2 milligrams orally every evening at 5:00 p.m. An order was written on 10/4/12 for the resident to have weekly PT/INR laboratory levels drawn. Another order was written on 10/4/12 to hold the Coumadin 2 milligrams on 10/4/12 for one day and then begin Coumadin 1 milligram daily. There was also an order written on 10/4/12 to obtain a PT/INR on 10/8/12. The 10/12 MAR (Medication Administration Record) was reviewed. The MAR indicated the resident was receiving Coumadin for a diagnosis of atrial fibrillation (an irregular heartbeat). The ordered dose of Coumadin 2 milligrams was circled as not given on 10/4/12 and circled with the word "hold" on 10/5/12. There was hand written line though the columns with the dates and "d/c 10/4/12 see new order" was handwritten across the column. There was a hand written entry on second			

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	page of the MAR for Coumadin 1 milligram orally to be given daily at 5:00 p.m. The medication was signed out as given 10/6/12, 10/7/12, 10/8/12, and 10/9/12 at 5:00 p.m. Vitamin K 5 milligrams IM was also signed out as given on 10/10/12 at 4:00 p.m. Review of the laboratory test results indicated a PT/INR test was completed on 10/4/12. The results were PT 35.6 and INR 3.5. The laboratory results indicated the Physician was notified of the above results on 10/4/12 and Physician orders were given to hold the Coumadin 2 milligram for one day and then start Coumadin 1 milligram daily. There was also an order to obtain another PT/INR laboratory test on 10/8/12. A PT/INR was completed on 10/8/12. The results were PT 44.0 and INR 4.4. There was no documentation of the Physician being notified of the 10/8/12 results. A weekly PT/INR was completed on 10/10/12 based on the Physician order for PT/INR levels to be completed weekly. The results of the 10/10/12 PT/INR were noted to be a "Critical" level. The results were PT 118.8 and INR 12.8. Review of the 12th Edition of the "Geriatric Dosage Handbook" included INR ranges based on indication of use (page 1650). The targeted INR for the			

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	treatment of atrial fibrillation was 2.5 with a targeted range of 2.0-3.0. The October 2012 Lab tracking Forms were reviewed. Resident name, test ordered, date to be done, date completed, date results returned, physician notification, responsible party notification and comments were to be filled out for each laboratory test ordered for each resident. The form indicated Resident #E was to have PT/INR laboratory tests drawn on 10/4/12, 10/10/12, 10/17/12, 10/24/12, and 10/31/12. The log did not list the PT/INR ordered on 10/4/12. The resident's name, test, and test dates were the only lines completed on the log. The other columns listed above were blank. The PT/INR ordered to be completed on 10/8/12 was not on the log. The results of the 10/4/12 PT/INR were not listed on the log. The 10/12 Nurses' Notes were reviewed. A late entry for 10/10/12 (no time listed) indicated the the Physician was made of aware of the Critical laboratory test results and orders were received to administer Vitamin K (a medication used to decrease the effects of Coumadin) 5 milligrams IM (intramuscularly) one time and to hold Coumadin until further notice. The entry also indicated no breakthrough bleeding or gastrointestinal bleeding was			

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	noted. An entry made on 10/11/12 at 2:00 p.m., indicated the resident had a large amount of blood noted in the stool and the resident was sent to the hospital 911. When interviewed on 10/22/12 at 1:00 p.m., the Risk Management RN indicated Resident #E was sent to the hospital on 10/11/12. The RN indicated the facility started doing a change of condition audit related to the hospitalization. The RN indicated she audits were done on 10/11/12 and she believed this to be when the facility determined the Physician was not notified of the 10/8/12 PT/INR results. When interviewed on 10/22/12 at 1:04 p.m., the Clinical Support Nurse indicated the Physician is to be called with abnormal lab results. The Nurse indicated laboratory requisitions were to be brought to Morning Meeting and reviewed. The Unit Manager is then to follow up and ensure the test is completed and follow up is provided. The RN also indicated there is a binder at each Nurses' station with "Lab Tracking" forms. The resident's name, test ordered, date completed, date results returned, MD notification, Responsible Party notification, and other comments are to be recorded on the monthly log. The Nurse indicated if there was a Morning Meeting on 10/8/12 this			

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	order for the 10/8/12 lab test should have been reviewed and follow up including obtaining results, completing notification should have been done. When interviewed on 10/23/12 at 8:00 a.m., the Clinical Support Nurse indicated when investigating the resident's hospitalization and elevated PT/INR level it appeared the Nurses may have interpreted the written order on the MAR for 1 milligram of Coumadin to be 7 milligrams. The Nurse indicated they reviewed the resident's orders, pharmacy punch cards, and the MAR. The Nurse indicated staff working on this shift the 10/6/12 thru 10/8/12 were interviewed. The facility investigation concluded the resident received Coumadin 1 milligram on 10/6/12 and 10/7/12 and 7 milligrams on 10/8/12 and 10/9/12 resulting in the resident's PT/INR levels rising significantly. The Nurse indicated LPN #1 worked 10/8/12 and 10/9/12 and signed out the doses of Coumadin on those two days. The Nurse indicated we first noted this error on 10/11/12 when audits were being done on resident's receiving Coumadin. When interviewed on 10/23/12 at 9:30 a.m., the Risk Management Nurse indicated a Morning Meeting was held on 10/8/12 and no meeting was held on			

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	10/9/12. The Past Noncompliance Immediate Jeopardy began on 10/8/12. The Immediate Jeopardy was removed and the deficient practice corrected by 10/12/12 after the facility implemented a systemic plan that included the following actions: completion of audits of Medication Administration Records, Physician orders, laboratory test results, and verification of the correct medications in the Medication Carts for 13 of 13 residents currently receiving Coumadin. The facility also implemented the use of individual Coagulation Records to be placed in the Medication Books for the 13 residents. This federal tag relates to Complaints IN00117692 and IN00118202. 3.1-48(a)(3)			

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F0333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure residents were free of significant medication errors related to the administration of anticoagulant (medications to prevent blood clotting) and anticonvulsant (medications to control seizure activity) medications for 2 of 6 residents reviewed for medication errors in the sample of 6. This resulted in the hospitalization for one resident who developed gastrointestinal bleeding after receiving the incorrect dose of an anticoagulant medication. (Residents #D and #E) Findings include: 1. The record for Resident #E was reviewed on 10/22/12 at 10:30 a.m. The resident's diagnoses included, but were not limited to, colon cancer, renal failure, high blood pressure, and arthritis. The resident was admitted to the facility on 10/3/12. The resident was sent to the hospital on 10/11/12 and was readmitted to the facility on 10/15/12. Review of the 10/12 Physician orders indicated there was an order written on 10/3/12 for the resident to receive	F0333	**F 333 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident E was readmitted to facility on 10.30.12 and is not receiving any Coumadin. Resident D Tegretol medications were reviewed with physician on 10.8.12 for clarification and noted. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All current residents receiving Coumadin were audited on 10.11.12 to ensure dosage of Coumadin and PT/INR laboratory orders for monitoring of Coumadin were conducted as ordered, results communicated to physician and changes implemented as ordered. Current residents are not receiving Tegretol except for Resident D. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nurses have been inserviced to write Coumadin orders numerically and alphabetically write out the**	11/22/2012

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	Coumadin (a medication to prevent blood clotting risk) 2 milligrams orally every evening at 5:00 p.m. An order was written on 10/4/12 for the resident to have weekly PT/INR laboratory levels drawn weekly. Another order was written on 10/4/12 to hold the Coumadin 2 milligrams on 10/4/12 for one day and then begin Coumadin 1 milligram daily. There was also an order written on 10/4/12 to obtain a PT/INR on 10/8/12. The 10/12 MAR (Medication Administration Record) was reviewed. The ordered dose of Coumadin 2 milligram was circled as not given on 10/4/12 and circled with the word "hold" on 10/5/12. There was hand written line though the columns with the dates and "d/c 10/4/12 see new order" was handwritten across the column. There was a hand written entry on second page of the MAR for Coumadin 1 milligram orally to be given daily at 5:00 p.m. The medication was signed out as given 10/6/12, 10/7/12, 10/8/12, and 10/9/12 at 5:00 p.m. Vitamin K 5 milligrams IM was also signed out as given on 10/10/12 at 4:00 p.m. Review of the laboratory test results indicated a PT/INR test was completed on 10/4/12. the results were PT 35.6 and INR 3.5. The laboratory results indicated		**dosage in milligrams. Inserviced on PT/INR form on when lab to be drawn. Licensed nurses have been inserviced on medication pass procedures and error prevention. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Director of nursing/designee will monitor by using an audit tool Coumadin and PT/INR daily for 90 days, then five days a week for 60days, then three days a week for 30 days. Audits will be reviewed in Quality Assurance meeting monthly times six months until substantial compliance is achieved. Director of nursing/designee will do medication pass competencies with three nurses weekly for 90 days, then 2 nurses weekly for 90 days. Competencies will be reviewed during Quality Assurance meeting monthly six months until substantial compliance is achieved. Date: November 22, 2012**	

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	the Physician was notified of the above results on 10/4/12 and Physician orders were given to hold the Coumadin 2 milligram for one day and then start Coumadin 1 milligram daily. There was also an order to obtain another PT/INR laboratory test on 10/8/12. A PT/INR was completed on 10/8/12. The results were PT 44.0 and INR 4.4. There was no documentation of the Physician being notified of the 10/8/12 results. A weekly PT/INR was completed on 10/10/12 based on the Physician order for PT/INR levels to be completed weekly. The results of the 10/10/12 PT/INR were noted to be at a "Critical" level. The results were PT 118.8 and INR 12.8. The 10/12 Nurses' Notes were reviewed. A late entry for 10/10/12 (no time listed) indicated the the Physician was made of aware of the Critical laboratory test results and orders were received to administer Vitamin K (a medication used to decrease the effects of Coumadin) 5 milligrams IM (intramuscularly) one time and to hold Coumadin until further notice. The entry also indicated no breakthrough bleeding or gastrointestinal bleeding was noted. An entry made on 10/11/12 at 2:00 p.m., indicated the resident had a large amount of blood noted in the stool and the resident was sent to the hospital 911.			

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	When interviewed on 10/23/12 at 8:00 a.m., the Clinical Support Nurse indicated when investigating the resident's hospitalization and elevated PT/INR level it appeared the Nurses may have interpreted the written order on the MAR for 1 milligram of Coumadin to be 7 milligrams. The Nurse indicated they reviewed the resident's orders, pharmacy punch cards, and the MAR. The Nurse indicated staff working on this shift the 10/6/12 thru 10/8/12 were interviewed. The facility investigation concluded the resident received Coumadin 1 milligram on 10/6/12 and 10/7/12 and 7 milligrams on 10/8/12 and 10/9/12 resulting in the resident's PT/INR levels rising significantly.. The Nurse indicated LPN #1 worked 10/8/12 and 10/9/12 and signed out the doses of Coumadin on those two days. We first noted this error on 10/11/12 when audits were being done on residents receiving Coumadin. 2. The record for Resident #D was reviewed on 10/22/12 at 11:00 a.m. The resident's diagnoses included, but were not limited to, epilepsy, stroke, respiratory failure, dementia, and glioma (tumor). The resident was sent to the hospital on 9/20/12 and was re admitted to the facility in 9/24/12. A Change in Condition Form completed			

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	on 9/20/12 at 7:42 a.m., indicated the CNA notified the Nurse that the resident was having a seizure and at 8:03 a.m., the resident was noted to have another seizure. The Physician was notified and orders were received to send the resident to the Emergency Room at the hospital. Review of the 10/12 MAR (Medication Administration Record) indicated there was a Physician's order for the resident to receive Tegretol (a medication to control seizure activity) 100 milligrams/5 mls (milliliters) take 25 mls orally three times a day. The administration times were to be upon rising, at lunch, and hs (hour of sleep). All the medication was signed out as given from 10/1/12 lunch time through 10/8/12 at upon rising times. The order was initially written on 9/24/12. The 10/12 MAR also listed Carbamazepine (generic name for Tegretol) 100 mg (milligrams) tab. Directly below the above line Tegretol 100 mg tablet - give 4 tablets orally every bedtime for 90 days was listed. The medication was signed out as given at bedtime 10/1/12 through 10/6/12. The MAR indicated the initial date for the Carbamazepine order was listed as 9/13/12. Review of the 10/12 Physician Order Statement indicated the order for the Carbamazepine 100 milligrams-give 4			

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	155764	A. BUILDING 00 B. WING	10/23/2012

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	tablets orally every bedtime appeared on Physician Order Statement. Marked over the order was writing which indicated the order had been changed on 9/24/12. Review of the laboratory tests results indicated a Tegretol level was obtained on 10/10/12. The level was 11.7. The therapeutic level was listed to be (8-12). When interviewed on 10/23/12 at 12:10 p.m., the Interim Director of Nursing indicated she met with Resident #D's family on Monday 10/8/12. She indicated the family voiced concerns related to observing a Nurse starting to administer Tegretol pills to the resident on 10/7/12 when she was supposed to receive the medication in a liquid form. The Interim Director of Nursing indicated she reviewed the resident's record and medications and determined there was a medication error. The Interim Director of Nursing indicated the resident had been receiving Tegretol in both the pill form and the liquid form at night from 10/1/12 through 10/6/12 due to a transcription error. The Interim Director of Nursing indicated the Nurse did not administer both the pill form and the liquid form of the Tegretol on 10/7/12. She indicated the medication cart was checked and both Tegretol elixir and Tegretol pills were in the cart. She also indicated the Nurse			

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	who worked on the 10/7/12 did not document anything about the doses nor did the Nurse notify her of the discrepancy on 10/7/12. The Interim Director of Nursing indicated she informed the Physician of the medication error on 10/8/12 and clarified the order for the medication. She also indicated the resident was noted to be lethargic on 10/10/12 and the Physician was notified and a Tegretol level was ordered. The Interim Director of Nursing indicated the 10/10/12 level was normal. This federal tag relates to Complaints IN00117692 and IN00118202. 3.1-48(c)(2)			

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F0505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to ensure Physician notification of laboratory tests results was completed in a timely manner for 3 residents in the sample of 6. (Residents #E, #F, and #G) Finding include: 1. The record for Resident #G was reviewed on 10/22/12 at 11:40 a.m. The resident's diagnoses included, but were not limited to, cerebral vascular accident (stroke), high blood pressure, chronic anemia, and diabetes mellitus. Review of the laboratory test results indicated a PT/INR laboratory test was completed on 9/24/12. The results indicated the PT level was 24.3 and the INR level was 2.3. The record indicated the Physician was notified of the results on 9/27/12. When interviewed on 10/22/12 at 1:00 p.m., the Clinical Support Nurse indicated the Physician should be notified of laboratory test results in timely manner. 2. The record for Resident #F was	F0505	**F 505 Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Residents E, F, and G had their labs notified to the physician and changes implemented as ordered. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Current residents have been audited to ensure labs were notified timely to the physician and changes implemented as ordered. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Licensed nurses have been inserviced on physician notification guidelines policy. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Director of health services/designee will audit lab draws daily for 90 days, then five days a week for 60 days, then three times a week for 30 days. audits will be reviewed during Quality Assurance meeting monthly times six**	11/22/2012

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	reviewed on 10/22/12 at 10:50 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, seizure and cerebral vascular disease. Review of the laboratory test results indicated laboratory tests results were completed on 9/24/12. The tests included a CBC (Complete Blood Count) and Chemistry Profile. The record indicated the Physician was notified of the results on 9/27/12. When interviewed on 10/22/12 at 1:00 p.m., the Clinical Support Nurse indicated the Physician should be notified of laboratory test results in timely manner. 3. The record for Resident #E was reviewed on 10/22/12 at 10:30 a.m. The resident's diagnoses included, but were not limited to, colon cancer, renal failure, high blood pressure, and arthritis. Review of the laboratory test results indicated a PT/INR test was completed on 10/8/12. The results were PT 44.0 and INR 4.4. There was no documentation of the Physician being notified of the 10/8/12 results. The current facility policy titled "Physician Notification Guidelines" was		**months until substantial compliance is achieved. Date November 22, 2012**	

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	reviewed on 10/22/12 at 1:30 p.m. The policy was dated 12/06/2007. The policy indicated the facility was to ensure the resident's Physician was aware of all diagnostic testing results in a timely manner. The policy indicated normal laboratory may be faxed to the Physician office with a follow up to ensure receipt. The policy also indicated if the facility does not receive a response to abnormal test results within 12 hours, the Nurse on duty was to call the Physician to obtain further instructions. When interviewed on 10/22/12 at 1:00 p.m., the Clinical Support Nurse indicated the Physician should be notified of laboratory test results in timely manner. This federal tag relates to Complaints IN00117692 and IN00118202. 3.1-49(f)(2)			

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F9999	STATE RULES 3.1-14 PERSONNEL (q)(7) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: Documentation of orientation to the facility and to the job specific skills. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure job specific orientation checklists were completed as required for 2 of 5 licensed nurses hired in the last 120 days. (LPN #3 and LPN #4) Findings include: The facility Employee files for 5 nurses hired in the last 120 day were reviewed on 10/23/12 at 2:35 p.m. There was no completed job specific orientation forms for the following staff: LPN #3- Hired on 10/3/12 LPN #4- Hired on 8/30/12 When interviewed on 10/23/12 at 3:00 p.m., the Human Resource (HR) Staff	F9999	The two employees affected by this citation were reviewed. They completed and signed their job specific orientation checklist and returned it to the HR Department/Business Office. All persoonel files were audited for job specific orientation checklists. Any personnel file to have been found without a job specific orientation checklist were corrected with a signed job specific orientation checklist. We retrained all hiring managers and our busienss office on our procedures and expectations that job specific orientation checklists be returned to the business office within 30 days from date of hire. ED and/or designee will review all personnel filles for the next 6 months to make sure job specific orientation checklist have been completed. Results will be reviewed at QA for the next 6 months and as needed thereafter. Date of compliance 11/22/12	11/22/2012

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	member indicated the Job Specific orientations should be completed and returned within two weeks. The HR staff member indicated the orientations for the above named nurses had not been received. This state tag relates to Complaint IN00117692. 3.1-14(q)(7)			